

AMENDED IN ASSEMBLY AUGUST 17, 2004

AMENDED IN SENATE MAY 12, 2004

SENATE BILL

No. 1347

Introduced by Senator Ducheny

February 18, 2004

An act to amend, repeal, and add Sections 1351.2 and 1367.01 of the Health and Safety Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

SB 1347, as amended, Ducheny. Mexican health plans.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the regulation of health care service plans by the Director of the Department of Managed Health Care. Existing law requires a health care service plan licensed under the laws of Mexico that elects to operate a health care service plan in this state to apply for licensure and comply with certain requirements, including offering and selling in this state only employer-sponsored group plan contracts exclusively for the benefit of citizens of Mexico legally employed in this state and their dependents. Existing law also requires any health care service plan that meets specified conditions to employ or designate a medical director who holds a license to practice medicine in this state.

This bill would, until January 1, 2008, delete the requirement that a Mexican health plan provide benefits only for citizens of Mexico and their dependents and would instead ~~allow~~ *require that it provide* benefits *only* ~~for citizens of Mexico~~ *Mexican nationals* legally employed in ~~this state, citizens of the United States living in Mexico,~~ *the County of San Diego or the County of Imperial,* and Mexican citizens who have become United States citizens ~~the County of San Diego or the County of Imperial,~~ and their dependents.

The bill would ~~also, until January 1, 2008, exempt~~ *require* a Mexican health plan ~~from the requirement that the plan~~ *to* employ or designate a medical director who holds a license to practice medicine in this state *or, for health care services that are to be provided or delivered wholly in Mexico, a medical director operating under the laws of Mexico.*

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Section 1351.2 of the Health and Safety Code
2 is amended to read:

3 1351.2. (a) If a prepaid health plan operating lawfully under
4 the laws of Mexico elects to operate a health care service plan in
5 this state, the prepaid health plan shall apply for licensure as a
6 health care service plan under this chapter by filing an application
7 for licensure in the form prescribed by the department and verified
8 by an authorized representative of the applicant. The prepaid
9 health plan shall be subject to the provisions of this chapter, and
10 the rules adopted by the director thereunder, as determined by the
11 director to be applicable. The application shall be accompanied by
12 the fee prescribed by subdivision (a) of Section 1356 and shall
13 demonstrate compliance with the following requirements:

14 (1) The prepaid health plan is constituted and operating
15 lawfully under the laws of Mexico and, if required by Mexican
16 law, is authorized as an Insurance Institution Specializing in
17 Health by the Mexican Insurance Commission. If the Mexican
18 Insurance Commission determines that the prepaid health plan is
19 not required to be authorized as an Insurance Institution
20 Specializing in Health under the laws of Mexico, the applicant
21 shall obtain written verification from the Mexican Insurance
22 Commission stating that the applicant is not required to be
23 authorized as an Insurance Institution Specializing in Health in
24 Mexico. A Mexican prepaid health plan that is not required to be
25 an Insurance Institution Specializing in Health shall obtain written
26 verification from the Mexican Ministry of Health that the prepaid
27 health plan and its provider network are operating in full
28 compliance of Mexican law.

29 (2) The prepaid health plan offers and sells in this state only
30 employer-sponsored group plan contracts exclusively for the

benefit of ~~citizens of Mexico~~ *Mexican nationals* legally employed in this state, ~~citizens of the United States living in Mexico, and Mexican citizens who have become United States citizens~~ *the County of San Diego or the County of Imperial*, and for the benefit of their dependents regardless of nationality, that pay for, reimburse the cost of, or arrange for the provision or delivery of health care services that are to be provided or delivered wholly in Mexico, except for the provision or delivery of those health care services set forth in paragraph (4).

(3) Solicitation of plan contracts in this state is made only through insurance brokers and agents licensed in this state or a third-party administrator licensed in this state, each of which is authorized to offer and sell plan group contracts.

(4) Group contracts provide, through a contract of insurance between the prepaid health plan and an insurer admitted in this state, for the reimbursement of emergency and urgent care services provided out of area as required by subdivision (h) of Section 1345.

(5) All advertising, solicitation material, disclosure statements, evidences of coverage, and contracts are in compliance with the appropriate provisions of this chapter and the rules or orders of the director. The director shall require that each of these documents contain a legend in 10-point type, in both English and Spanish, declaring that the health care service plan contract provided by the prepaid health plan may be limited as to benefits, rights, and remedies under state and federal law.

(6) All funds received by the prepaid health plan from a subscriber are deposited in an account of a bank organized under the laws of this state or in an account of a national bank located in this state.

(7) The prepaid health plan maintains a tangible net equity as required by this chapter and the rules of the director, as calculated under United States generally accepted accounting principles, in the amount of a least one million dollars (\$1,000,000). In lieu of an amount in excess of the minimum tangible net equity of one million dollars (\$1,000,000), the prepaid health plan may demonstrate a reasonable acceptable alternative reimbursement arrangement that the director may in his or her discretion accept. The prepaid health plan shall also maintain a fidelity bond and a

1 surety bond as required by Section 1376 and the rules of the
2 director.

3 (8) The prepaid health plan agrees to make all of its books and
4 records, including the books and records of health care providers
5 in Mexico, available to the director in the form and at the time and
6 place requested by the director. Books and records shall be made
7 available to the director no later than 24 hours from the date of the
8 request.

9 (9) The prepaid health plan files a consent to service of process
10 with the director and agrees to be subject to the laws of this state
11 and the United States in any investigation, examination, dispute,
12 or other matter arising from the advertising, solicitation, or offer
13 and sale of a plan contract, or the management or provision of
14 health care services in this state or throughout the United States.
15 The prepaid health plan shall agree to notify the director,
16 immediately and in no case later than one business day, if it is
17 subject to any investigation, examination, or administrative or
18 legal action relating to the prepaid health plan or the operations of
19 the prepaid health plan initiated by the government of Mexico or
20 the government of any state of Mexico against the prepaid health
21 plan or any officer, director, security holder, or contractor owning
22 10 percent or more of the securities of the prepaid health plan. The
23 prepaid health plan shall agree that in the event of conflict of laws
24 in any action arising out of the license, the laws of California and
25 the United States shall apply.

26 (10) The prepaid health plan agrees that disputes arising from
27 the group contracts involving group contractholders and providers
28 of health care services in the United States shall be subject to the
29 jurisdiction of the courts of this state and the United States.

30 (11) *The prepaid health plan shall employ or designate a*
31 *medical director who holds an unrestricted license to practice*
32 *medicine in this state issued pursuant to Section 2050 of the*
33 *Business and Professions Code or pursuant to the Osteopathic Act*
34 *for health care services set forth in paragraph (4). For health care*
35 *services that are to be provided or delivered wholly in Mexico, the*
36 *prepaid health plan may employ or designate a medical director*
37 *operating under the laws of Mexico.*

38 (b) The prepaid health plan shall pay the application processing
39 fee and other fees and assessments set forth in Section 1356. The
40 director, by order, may designate provisions of this chapter and



1 rules adopted thereunder that need not be applied to a prepaid
2 health plan licensed under the laws of Mexico when consistent
3 with the intent and purpose of this chapter, and in the public
4 interest.

5 (c) If the plan ceases to operate legally in Mexico, the director
6 shall immediately deliver written notice to the health care service
7 plan that it is not in compliance with the provisions of this section.
8 If this occurs, a health care service plan shall do all of the
9 following:

10 (1) Provide the director with written proof that the prepaid
11 health plan has complied with the laws of Mexico not later than 45
12 days after the date the written notice is received by the health care
13 service plan.

14 (2) If, by the 45th day, the health care service plan is unable to
15 provide written confirmation that it is in full compliance with
16 Mexican law, the director shall notify the health care service plan
17 in writing that it is prohibited from accepting any new enrollees or
18 subscribers. The health care service plan shall be given an
19 additional 180 days to comply with Mexican law or to become a
20 licensed health care service plan.

21 (3) If, at the end of the 180-day notice period in paragraph (2),
22 the health care service plan has not complied with the laws of
23 Mexico or California, the director shall issue an order that the
24 health care service plan cease and desist operations in California.

25 (d) This section shall be repealed on January 1, 2008, unless a
26 later enacted statute, that becomes effective on or before January
27 1, 2008, deletes or extends the dates on which it becomes
28 inoperative and is repealed.

29 SEC. 2. Section 1351.2 is added to the Health and Safety
30 Code, to read:

31 1351.2. (a) If a prepaid health plan operating lawfully under
32 the laws of Mexico elects to operate a health care service plan in
33 this state, the prepaid health plan shall apply for licensure as a
34 health care service plan under this chapter by filing an application
35 for licensure in the form prescribed by the department and verified
36 by an authorized representative of the applicant. The prepaid
37 health plan shall be subject to the provisions of this chapter, and
38 the rules adopted by the director thereunder, as determined by the
39 director to be applicable. The application shall be accompanied by

1 the fee prescribed by subdivision (a) of Section 1356 and shall
2 demonstrate compliance with the following requirements:

3 (1) The prepaid health plan is constituted and operating
4 lawfully under the laws of Mexico and, if required by Mexican
5 law, is authorized as an Insurance Institution Specializing in
6 Health by the Mexican Insurance Commission. If the Mexican
7 Insurance Commission determines that the prepaid health plan is
8 not required to be authorized as an Insurance Institution
9 Specializing in Health under the laws of Mexico, the applicant
10 shall obtain written verification from the Mexican Insurance
11 Commission stating that the applicant is not required to be
12 authorized as an Insurance Institution Specializing in Health in
13 Mexico. A Mexican prepaid health plan not required to be an
14 Insurance Institution Specializing in Health shall obtain written
15 verification from the Mexican Ministry of Health that the prepaid
16 health plan and its provider network are operating in full
17 compliance of Mexican law.

18 (2) The prepaid health plan offers and sells in this state only
19 employer-sponsored group plan contracts exclusively for the
20 benefit of citizens of Mexico legally employed in this state, and for
21 the benefit of their dependents regardless of nationality, that pay
22 for, reimburse the cost of, or arrange for the provision or delivery
23 of health care services that are to be provided or delivered wholly
24 in Mexico, except for the provision or delivery of those health care
25 services set forth in subparagraphs (A) and (B) of paragraph (4).

26 (3) Solicitation of plan contracts in this state is made only
27 through insurance brokers and agents licensed in this state or a
28 third-party administrator licensed in this state, each of which is
29 authorized to offer and sell plan group contracts.

30 (4) Group contracts provide, through a contract of insurance
31 between the prepaid health plan and an insurer admitted in this
32 state, for the reimbursement of emergency and urgent care services
33 provided out of area as required by subdivision (h) of Section
34 1345.

35 (5) All advertising, solicitation material, disclosure statements,
36 evidences of coverage, and contracts are in compliance with the
37 appropriate provisions of this chapter and the rules or orders of the
38 director. The director shall require that each of these documents
39 contain a legend in 10-point type, in both English and Spanish,
40 declaring that the health care service plan contract provided by the

1 prepaid health plan may be limited as to benefits, rights, and
2 remedies under state and federal law.

3 (6) All funds received by the prepaid health plan from a
4 subscriber are deposited in an account of a bank organized under
5 the laws of this state or in an account of a national bank located in
6 this state.

7 (7) The prepaid health plan maintains a tangible net equity as
8 required by this chapter and the rules of the director, as calculated
9 under United States generally accepted accounting principles, in
10 the amount of a least one million dollars (\$1,000,000). In lieu of
11 an amount in excess of the minimum tangible net equity of one
12 million dollars (\$1,000,000), the prepaid health plan may
13 demonstrate a reasonable acceptable alternative reimbursement
14 arrangement that the director may in his or her discretion accept.
15 The prepaid health plan shall also maintain a fidelity bond and a
16 surety bond as required by Section 1376 and the rules of the
17 director.

18 (8) The prepaid health plan agrees to make all of its books and
19 records, including the books and records of health care providers
20 in Mexico, available to the director in the form and at the time and
21 place requested by the director. Books and records shall be made
22 available to the director no later than 24 hours from the date of the
23 request.

24 (9) The prepaid health plan files a consent to service of process
25 with the director and agrees to be subject to the laws of this state
26 and the United States in any investigation, examination, dispute,
27 or other matter arising from the advertising, solicitation, or offer
28 and sale of a plan contract, or the management or provision of
29 health care services in this state or throughout the United States.
30 The prepaid health plan shall agree to notify the director,
31 immediately and in no case later than one business day, if it is
32 subject to any investigation, examination, or administrative or
33 legal action relating to the prepaid health plan or the operations of
34 the prepaid health plan initiated by the government of Mexico or
35 the government of any state of Mexico against the prepaid health
36 plan or any officer, director, security holder, or contractor owning
37 10 percent or more of the securities of the prepaid health plan. The
38 prepaid health plan shall agree that in the event of conflict of laws
39 in any action arising out of the license, the laws of California and
40 the United States shall apply.

1 (10) The prepaid health plan agrees that disputes arising from
2 the group contracts involving group contractholders and providers
3 of health care services in the United States shall be subject to the
4 jurisdiction of the courts of this state and the United States.

5 (b) The prepaid health plan shall pay the application processing
6 fee and other fees and assessments set forth in Section 1356. The
7 director, by order, may designate provisions of this chapter and
8 rules adopted thereunder that need not be applied to a prepaid
9 health plan licensed under the laws of Mexico when consistent
10 with the intent and purpose of this chapter, and in the public
11 interest.

12 (c) If the plan ceases to operate legally in Mexico, the director
13 shall immediately deliver written notice to the health care service
14 plan that it is not in compliance with the provisions of this section.
15 If this occurs, a health care service plan shall do all of the
16 following:

17 (1) Provide the director with written proof that the prepaid
18 health plan has complied with the laws of Mexico not later than 45
19 days after the date the written notice is received by the health care
20 service plan.

21 (2) If, by the 45th day, the health care service plan is unable to
22 provide written confirmation it is in full compliance with Mexican
23 law, the director shall notify the health care service plan in writing
24 that it is prohibited from accepting any new enrollees or
25 subscribers. The health care service plan shall be given an
26 additional 180 days to comply with Mexican law or to become a
27 licensed health care service plan.

28 (3) If, at the end of the 180-day notice period in paragraph (2),
29 the health care service plan has not complied with the laws of
30 Mexico or California, the director shall issue an order that the
31 health care service plan cease and desist operations in California.

32 (d) This section shall become operative on January 1, 2008.

33 SEC. 3. Section 1367.01 of the Health and Safety Code is
34 amended to read:

35 1367.01. (a) A health care service plan and any entity with
36 which it contracts for services that include utilization review or
37 utilization management functions, that prospectively,
38 retrospectively, or concurrently reviews and approves, modifies,
39 delays, or denies, based in whole or in part on medical necessity,
40 requests by providers prior to, retrospectively, or concurrent with

1 the provision of health care services to enrollees, or that delegates
2 these functions to medical groups or independent practice
3 associations or to other contracting providers, shall comply with
4 this section.

5 (b) A health care service plan that is subject to this section shall
6 have written policies and procedures establishing the process by
7 which the plan prospectively, retrospectively, or concurrently
8 reviews and approves, modifies, delays, or denies, based in whole
9 or in part on medical necessity, requests by providers of health care
10 services for plan enrollees. These policies and procedures shall
11 ensure that decisions based on the medical necessity of proposed
12 health care services are consistent with criteria or guidelines that
13 are supported by clinical principles and processes. These criteria
14 and guidelines shall be developed pursuant to Section 1363.5.
15 These policies and procedures, and a description of the process by
16 which the plan reviews and approves, modifies, delays, or denies
17 requests by providers prior to, retrospectively, or concurrent with
18 the provision of health care services to enrollees, shall be filed with
19 the director for review and approval, and shall be disclosed by the
20 plan to providers and enrollees upon request, and by the plan to the
21 public upon request.

22 (c) A health care service plan subject to this section, except a
23 plan that meets the requirements of Section 1351.2, shall employ
24 or designate a medical director who holds an unrestricted license
25 to practice medicine in this state issued pursuant to Section 2050
26 of the Business and Professions Code or pursuant to the
27 Osteopathic Act, or, if the plan is a specialized health care service
28 plan, a clinical director with California licensure in a clinical area
29 appropriate to the type of care provided by the specialized health
30 care service plan. The medical director or clinical director shall
31 ensure that the process by which the plan reviews and approves,
32 modifies, or denies, based in whole or in part on medical necessity,
33 requests by providers prior to, retrospectively, or concurrent with
34 the provision of health care services to enrollees, complies with the
35 requirements of this section.

36 (d) If health plan personnel, or individuals under contract to the
37 plan to review requests by providers, approve the provider's
38 request, pursuant to subdivision (b), the decision shall be
39 communicated to the provider pursuant to subdivision (h).



(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).

(f) The criteria or guidelines used by the health care service plan to determine whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall be consistent with clinical principles and processes. These criteria and guidelines shall be developed pursuant to the requirements of Section 1363.5.

(g) If the health care service plan requests medical information from providers in order to determine whether to approve, modify, or deny requests for authorization, the plan shall request only the information reasonably necessary to make the determination.

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:

(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.

1 (2) When the enrollee's condition is such that the enrollee faces
2 an imminent and serious threat to his or her health including, but
3 not limited to, the potential loss of life, limb, or other major bodily
4 function, or the normal timeframe for the decisionmaking process,
5 as described in paragraph (1), would be detrimental to the
6 enrollee's life or health or could jeopardize the enrollee's ability
7 to regain maximum function, decisions to approve, modify, or
8 deny requests by providers prior to, or concurrent with, the
9 provision of health care services to enrollees, shall be made in a
10 timely fashion appropriate for the nature of the enrollee's
11 condition, not to exceed 72 hours after the plan's receipt of the
12 information reasonably necessary and requested by the plan to
13 make the determination. Nothing in this section shall be construed
14 to alter the requirements of subdivision (b) of Section 1371.4.
15 Notwithstanding Section 1371.4, the requirements of this division
16 shall be applicable to all health plans and other entities conducting
17 utilization review or utilization management.

18 (3) Decisions to approve, modify, or deny requests by
19 providers for authorization prior to, or concurrent with, the
20 provision of health care services to enrollees shall be
21 communicated to the requesting provider within 24 hours of the
22 decision. Except for concurrent review decisions pertaining to
23 care that is underway, which shall be communicated to the
24 enrollee's treating provider within 24 hours, decisions resulting in
25 denial, delay, or modification of all or part of the requested health
26 care service shall be communicated to the enrollee in writing
27 within two business days of the decision. In the case of concurrent
28 review, care shall not be discontinued until the enrollee's treating
29 provider has been notified of the plan's decision and a care plan has
30 been agreed upon by the treating provider that is appropriate for
31 the medical needs of that patient.

32 (4) Communications regarding decisions to approve requests
33 by providers prior to, retrospectively, or concurrent with the
34 provision of health care services to enrollees shall specify the
35 specific health care service approved. Responses regarding
36 decisions to deny, delay, or modify health care services requested
37 by providers prior to, retrospectively, or concurrent with the
38 provision of health care services to enrollees shall be
39 communicated to the enrollee in writing, and to providers initially
40 by telephone or facsimile, except with regard to decisions rendered

1 retrospectively, and then in writing, and shall include a clear and
2 concise explanation of the reasons for the plan's decision, a
3 description of the criteria or guidelines used, and the clinical
4 reasons for the decisions regarding medical necessity. Any written
5 communication to a physician or other health care provider of a
6 denial, delay, or modification of a request shall include the name
7 and telephone number of the health care professional responsible
8 for the denial, delay, or modification. The telephone number
9 provided shall be a direct number or an extension, to allow the
10 physician or health care provider easily to contact the professional
11 responsible for the denial, delay, or modification. Responses shall
12 also include information as to how the enrollee may file a
13 grievance with the plan pursuant to Section 1368, and in the case
14 of Medi-Cal enrollees, shall explain how to request an
15 administrative hearing and aid paid pending under Sections
16 51014.1 and 51014.2 of Title 22 of the California Code of
17 Regulations.

18 (5) If the health care service plan cannot make a decision to
19 approve, modify, or deny the request for authorization within the
20 timeframes specified in paragraph (1) or (2) because the plan is not
21 in receipt of all of the information reasonably necessary and
22 requested, or because the plan requires consultation by an expert
23 reviewer, or because the plan has asked that an additional
24 examination or test be performed upon the enrollee, provided the
25 examination or test is reasonable and consistent with good medical
26 practice, the plan shall, immediately upon the expiration of the
27 timeframe specified in paragraph (1) or (2) or as soon as the plan
28 becomes aware that it will not meet the timeframe, whichever
29 occurs first, notify the provider and the enrollee, in writing, that
30 the plan cannot make a decision to approve, modify, or deny the
31 request for authorization within the required timeframe, and
32 specify the information requested but not received, or the expert
33 reviewer to be consulted, or the additional examinations or tests
34 required. The plan shall also notify the provider and enrollee of the
35 anticipated date on which a decision may be rendered. Upon
36 receipt of all information reasonably necessary and requested by
37 the plan, the plan shall approve, modify, or deny the request for
38 authorization within the timeframes specified in paragraph (1) or
39 (2), whichever applies.



(6) If the director determines that a health care service plan has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected, in accordance with subdivision (a) of Section 1397. The administrative penalties shall not be deemed an exclusive remedy for the director. These penalties shall be paid to the State Managed Care Fund.

(i) A health care service plan subject to this section shall maintain telephone access for providers to request authorization for health care services.

(j) A health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

(k) The director shall review a health care service plan's compliance with this section as part of its periodic onsite medical survey of each plan undertaken pursuant to Section 1380, and shall include a discussion of compliance with this section as part of its report issued pursuant to that section.

(l) This section shall not apply to decisions made for the care or treatment of the sick who depend upon prayer or spiritual means for healing in the practice of religion as set forth in subdivision (a) of Section 1270.

(m) Nothing in this section shall cause a health care service plan to be defined as a health care provider for purposes of any provision of law, including, but not limited to, Section 6146 of the Business and Professions Code, Sections 3333.1 and 3333.2 of the

1 Civil Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of
2 the Code of Civil Procedure.

3 (n) This section shall be repealed on January 1, 2008, unless a
4 later enacted statute, that becomes effective on or before January
5 1, 2008, deletes or extends the dates on which it becomes
6 inoperative and is repealed.

7 SEC. 4. Section 1367.01 is added to the Health and Safety
8 Code, to read:

9 1367.01. (a) A health care service plan and any entity with
10 which it contracts for services that include utilization review or
11 utilization management functions, that prospectively,
12 retrospectively, or concurrently reviews and approves, modifies,
13 delays, or denies, based in whole or in part on medical necessity,
14 requests by providers prior to, retrospectively, or concurrent with
15 the provision of health care services to enrollees, or that delegates
16 these functions to medical groups or independent practice
17 associations or to other contracting providers, shall comply with
18 this section.

19 (b) A health care service plan that is subject to this section shall
20 have written policies and procedures establishing the process by
21 which the plan prospectively, retrospectively, or concurrently
22 reviews and approves, modifies, delays, or denies, based in whole
23 or in part on medical necessity, requests by providers of health care
24 services for plan enrollees. These policies and procedures shall
25 ensure that decisions based on the medical necessity of proposed
26 health care services are consistent with criteria or guidelines that
27 are supported by clinical principles and processes. These criteria
28 and guidelines shall be developed pursuant to Section 1363.5.
29 These policies and procedures, and a description of the process by
30 which the plan reviews and approves, modifies, delays, or denies
31 requests by providers prior to, retrospectively, or concurrent with
32 the provision of health care services to enrollees, shall be filed with
33 the director for review and approval, and shall be disclosed by the
34 plan to providers and enrollees upon request, and by the plan to the
35 public upon request.

36 (c) A health care service plan subject to this section shall
37 employ or designate a medical director who holds an unrestricted
38 license to practice medicine in this state issued pursuant to Section
39 2050 of the Business and Professions Code or pursuant to the
40 Osteopathic Act, or, if the plan is a specialized health care service



plan, a clinical director with California licensure in a clinical area appropriate to the type of care provided by the specialized health care service plan. The medical director or clinical director shall ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, complies with the requirements of this section.

(d) If health plan personnel, or individuals under contract to the plan to review requests by providers, approve the provider's request, pursuant to subdivision (b), the decision shall be communicated to the provider pursuant to subdivision (h).

(e) An individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may not deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).

(f) The criteria or guidelines used by the health care service plan to determine whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall be consistent with clinical principles and processes. These criteria and guidelines shall be developed pursuant to the requirements of Section 1363.5.

(g) If the health care service plan requests medical information from providers in order to determine whether to approve, modify, or deny requests for authorization, the plan shall request only the information reasonably necessary to make the determination.

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, every health care service plan subject to this section shall meet the following requirements:

(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2),

1 shall be made in a timely fashion appropriate for the nature of the
2 enrollee's condition, not to exceed five business days from the
3 plan's receipt of the information reasonably necessary and
4 requested by the plan to make the determination. In cases where
5 the review is retrospective, the decision shall be communicated to
6 the individual who received services, or to the individual's
7 designee, within 30 days of the receipt of information that is
8 reasonably necessary to make this determination, and shall be
9 communicated to the provider in a manner that is consistent with
10 current law. For purposes of this section, retrospective reviews
11 shall be for care rendered on or after January 1, 2000.

12 (2) When the enrollee's condition is such that the enrollee faces
13 an imminent and serious threat to his or her health including, but
14 not limited to, the potential loss of life, limb, or other major bodily
15 function, or the normal timeframe for the decisionmaking process,
16 as described in paragraph (1), would be detrimental to the
17 enrollee's life or health or could jeopardize the enrollee's ability
18 to regain maximum function, decisions to approve, modify, or
19 deny requests by providers prior to, or concurrent with, the
20 provision of health care services to enrollees, shall be made in a
21 timely fashion appropriate for the nature of the enrollee's
22 condition, not to exceed 72 hours after the plan's receipt of the
23 information reasonably necessary and requested by the plan to
24 make the determination. Nothing in this section shall be construed
25 to alter the requirements of subdivision (b) of Section 1371.4.
26 Notwithstanding Section 1371.4, the requirements of this division
27 shall be applicable to all health plans and other entities conducting
28 utilization review or utilization management.

29 (3) Decisions to approve, modify, or deny requests by
30 providers for authorization prior to, or concurrent with, the
31 provision of health care services to enrollees shall be
32 communicated to the requesting provider within 24 hours of the
33 decision. Except for concurrent review decisions pertaining to
34 care that is underway, which shall be communicated to the
35 enrollee's treating provider within 24 hours, decisions resulting in
36 denial, delay, or modification of all or part of the requested health
37 care service shall be communicated to the enrollee in writing
38 within two business days of the decision. In the case of concurrent
39 review, care shall not be discontinued until the enrollee's treating
40 provider has been notified of the plan's decision, and a care plan



1 has been agreed upon by the treating provider that is appropriate
2 for the medical needs of that patient.

3 (4) Communications regarding decisions to approve requests
4 by providers prior to, retrospectively, or concurrent with the
5 provision of health care services to enrollees shall specify the
6 specific health care service approved. Responses regarding
7 decisions to deny, delay, or modify health care services requested
8 by providers prior to, retrospectively, or concurrent with the
9 provision of health care services to enrollees shall be
10 communicated to the enrollee in writing, and to providers initially
11 by telephone or facsimile, except with regard to decisions rendered
12 retrospectively, and then in writing, and shall include a clear and
13 concise explanation of the reasons for the plan's decision, a
14 description of the criteria or guidelines used, and the clinical
15 reasons for the decisions regarding medical necessity. Any written
16 communication to a physician or other health care provider of a
17 denial, delay, or modification of a request shall include the name
18 and telephone number of the health care professional responsible
19 for the denial, delay, or modification. The telephone number
20 provided shall be a direct number or an extension, to allow the
21 physician or health care provider easily to contact the professional
22 responsible for the denial, delay, or modification. Responses shall
23 also include information as to how the enrollee may file a
24 grievance with the plan pursuant to Section 1368, and in the case
25 of Medi-Cal enrollees, shall explain how to request an
26 administrative hearing and aid paid pending under Sections
27 51014.1 and 51014.2 of Title 22 of the California Code of
28 Regulations.

29 (5) If the health care service plan cannot make a decision to
30 approve, modify, or deny the request for authorization within the
31 timeframes specified in paragraph (1) or (2) because the plan is not
32 in receipt of all of the information reasonably necessary and
33 requested, or because the plan requires consultation by an expert
34 reviewer, or because the plan has asked that an additional
35 examination or test be performed upon the enrollee, provided the
36 examination or test is reasonable and consistent with good medical
37 practice, the plan shall, immediately upon the expiration of the
38 timeframe specified in paragraph (1) or (2) or as soon as the plan
39 becomes aware that it will not meet the timeframe, whichever
40 occurs first, notify the provider and the enrollee, in writing, that

1 the plan cannot make a decision to approve, modify, or deny the
2 request for authorization within the required timeframe, and
3 specify the information requested but not received, or the expert
4 reviewer to be consulted, or the additional examinations or tests
5 required. The plan shall also notify the provider and enrollee of the
6 anticipated date on which a decision may be rendered. Upon
7 receipt of all information reasonably necessary and requested by
8 the plan, the plan shall approve, modify, or deny the request for
9 authorization within the timeframes specified in paragraph (1) or
10 (2), whichever applies.

11 (6) If the director determines that a health care service plan has
12 failed to meet any of the timeframes in this section, or has failed
13 to meet any other requirement of this section, the director may
14 assess, by order, administrative penalties for each failure. A
15 proceeding for the issuance of an order assessing administrative
16 penalties shall be subject to appropriate notice to, and an
17 opportunity for a hearing with regard to, the person affected, in
18 accordance with subdivision (a) of Section 1397. The
19 administrative penalties shall not be deemed an exclusive remedy
20 for the director. These penalties shall be paid to the State Managed
21 Care Fund.

22 (i) A health care service plan subject to this section shall
23 maintain telephone access for providers to request authorization
24 for health care services.

25 (j) A health care service plan subject to this section that reviews
26 requests by providers prior to, retrospectively, or concurrent with,
27 the provision of health care services to enrollees shall establish, as
28 part of the quality assurance program required by Section 1370, a
29 process by which the plan's compliance with this section is
30 assessed and evaluated. The process shall include provisions for
31 evaluation of complaints, assessment of trends, implementation of
32 actions to correct identified problems, mechanisms to
33 communicate actions and results to the appropriate health plan
34 employees and contracting providers, and provisions for
35 evaluation of any corrective action plan and measurements of
36 performance.

37 (k) The director shall review a health care service plan's
38 compliance with this section as part of its periodic onsite medical
39 survey of each plan undertaken pursuant to Section 1380, and shall



1 include a discussion of compliance with this section as part of its
2 report issued pursuant to that section.

3 (l) This section shall not apply to decisions made for the care
4 or treatment of the sick who depend upon prayer or spiritual means
5 for healing in the practice of religion as set forth in subdivision (a)
6 of Section 1270.

7 (m) Nothing in this section shall cause a health care service plan
8 to be defined as a health care provider for purposes of any
9 provision of law, including, but not limited to, Section 6146 of the
10 Business and Professions Code, Sections 3333.1 and 3333.2 of the
11 Civil Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of
12 the Code of Civil Procedure.

13 (n) This section shall become operative on January 1, 2008.

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